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HOW RESEARCH CAN AFFECT POLICY AND PROGRAMME ADVOCACY: EXAMPLE FROM A THREE-COUNTRY STUDY ON ABORTION COMPLICATIONS IN SUB-SAHARAN AFRICA
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HOW RESEARCH CAN AFFECT POLICY AND PROGRAMME ADVOCACY: EXAMPLE FROM A THREE-COUNTRY STUDY ON ABORTION COMPLICATIONS IN SUB-SAHARAN AFRICA

S. N. KINOTI, L. GAFFIKIN and J. BENSON

ABSTRACT

Objective: **To provide a basis for continued policy dialogue and reform to address the problem of death due to abortion complications among the ECSA Health Community countries. The anticipated short-term outcome of this study was increased awareness among African health officials about the problem of incomplete abortion in SSA, especially CRHCS/ECSA countries.**

Design: **The study undertaken in 1993/1994, involved primary data collection of abortion-related morbidity and mortality statistics, the cost of treating patients with abortion complications and provider and abortion patient perspectives. Data were collected via one on one interviews and reviews of logbook data. A computerized literature review on abortion in the region covering the years 1980-1994 complemented the primary data collection.**

Study Setting: **Primary data collection was conducted in three countries (Zambia, Uganda and Malawi) at selected districts and tertiary care hospitals.**

Subjects: **Nurses and physicians providing care to women with complications of abortion in participating hospitals were interviewed as well as hospital administrators. Women receiving care in the selected hospitals during the data collection period also were interviewed.**

Main outcome measures: **This analysis focused on cross-country comparisons of nurse and doctor attitudes and knowledge about abortion and family planning-related issues.**

Interventions: **At a 1994 CHRCS conference, Health Ministers from 12 Commonwealth countries reviewed and endorsed the results of this study. In a 1995 ECSA Director Joint Consultative Committee meeting, participants discussed the study findings and developed regional action plans which were subsequently endorsed by the Health Ministers' at their 1995 annual conference.**

Results: **Abortion complication patients in the three countries were on average 24-26 years old with two children. Patients experienced long hospital stays while receiving care for complications. The average monthly number of post-abortion patients was substantially higher in urban facilities as compared to mixed/rural ones. Opinions regarding factors that led to the abortion, access to abortion services and the legal provisions surrounding abortion were inconsistent between doctors and nurses. Patients were aware that complications of abortion were a major cause of maternal mortality. Overall, provider opinion about access to family planning (FP) information among abortion complication patients was also inconsistent between doctors and nurses but there was agreement on factors influencing use of FP. Opinions regarding access to FP services both before and after the abortion varied from easy to very difficult to obtain.**

Conclusions: **These data represent the situation as it was in the region some years ago and the paper describes important implications of the findings for policy and programme development. This research provided some impetus for stakeholders in these countries to put safe abortion and management of abortion complications on their health agenda. Ensuring that research results will be shared with appropriate decision-makers is key to maximizing the extent to which research findings may affect policy and programme advocacy.**

INTRODUCTION

Induced abortion is relatively common in sub-Saharan Africa (SSA), although abortion is legal only under narrow restrictions in most countries. Even where laws do not forbid abortion, access to safe abortion services is often limited. As is the case in many geographic areas with only illegal or poorly accessible abortion services, complications of unsafely-performed abortions are high in SSA. In East, Central and southern Africa(1) for example, complications of abortion constitute 30% of maternal mortality.

The Commonwealth Regional Health Community (CRHCS) for East, Central and Southern Africa (ECSA), an Arusha-based organisation, was established in 1974 to foster cooperation and collaboration in health among member states through promoting efficiency and relevance in the provision of quality health services in the region. Every year, the Regional Health Ministers of ECSA meet to review the results of health research in the region and to pass resolutions aimed at addressing priorities. Based on the findings of the 1992 ECSA study referenced above, in 1993 the Health Ministers passed a resolution at their annual conference calling for immediate action to address the problem of abortion complications. This call coincided with increased commitment on the part of international development agencies working in women's reproductive health to reduce the number of deaths due to abortion complications globally. Consequently, in 1994, the CRHCS joined with the JHPIEGO Corporation and Ipas to conduct a study to document factors affecting abortion complications in sub-Saharan Africa (SSA). It was intended that this document would provide a basis for continued policy dialogue and reform to address the problem of death due to abortion complications among the SSA Commonwealth countries.

MATERIALS AND METHODS

The study involved two components(i) a literature review on abortion in the region covering the years 1980-1994 and(ii) primary data collection in three SSA Commonwealth countries (Zambia, Uganda and Malawi). The literature review involved a computerised search for published literature on abortion using various bibliographic databases and a manual search for any unpublished documents (Grey literature) available in SSA Commonwealth countries. Primary data collection focused on hospital-based morbidity and mortality statistics, the cost of treating patients with abortion complications provider and abortion patient perspectives in three of the thirteen SSA Commonwealth countries (Table 1). Three countries were selected based on time and budgetary constraints, and these three countries were chosen because(i) they had expressed interest in participating in the study(ii) they had similar abortion related maternal mortality statistics and(iii) because the three had different abortion laws and administrative arrangements governing abortion and management of abortion complications. While Uganda and Malawi were similar regarding abortion laws and administrative arrangements for management of abortion complications, Zambia was quite liberal.

Table 1

Providers and patients interviewed

Country	Provider		Patients	
	No.	%	No.	%
Zambia	64	56.2	55	30.2
Uganda	17	14.9	77	42.3
Malawi	33	28.9	50	27.5
Total	114	100	182	100

Primary data were obtained in four health facilities (one tertiary and three district facilities) in each of the three countries from the following sources: ward logbooks and administrator, provider and patient interviews. The findings from both study components (and 244 abstracts) were compiled into a large reference document " Monograph on Complications of Unsafe Abortion in Africa", Kinoti *et al.*(2). In addition, key points were summarised in a smaller policy-oriented booklet entitled "Addressing Complications of Unsafe Abortion in Sub-Saharan Africa: Programme and Policy Actions"(3). Individual country reports were produced for local use and a synopsis of the literature review findings was published in the journal of Health Policy and Planning(4). This paper presents not previously published results of additional country primary data analyses for Uganda, Malawi and Zambia, highlighting the effect of factors such as professional care and facility location on select study variables on post abortion patients primarily, policy implications and developments in post abortion care (PAC) in the region subsequent to this effort.

RESULTS

Ward logbook data; Patient and service characteristics: In our study, abortion complication patients in the three countries were young women. They experienced long hospital stays while receiving care for complications and the majority of those seeking care, received it at participating tertiary facilities versus participating district facilities. Not all facilities where PAC is provided in these countries were surveyed, so this finding is not necessarily representative of the degree to which PAC services were accessible at the time of the study in these countries. The data do, however, provide a good description of PAC services providers and patients in the facilities studied. Furthermore, our "snapshot" of PAC at the facilities studied does provide insight into other hospitals where PAC may be provided in similar fashion. The average age and parity of post abortion patients were similar across the three countries, the majority of patients being between 24 to 26 years of age and having two children. The average age was slightly higher among those seen in mixed/rural facilities as compared to urban ones (28 versus 23 years, respectively). The average monthly number of post-abortion patients was substantially higher in urban facilities as compared to mixed/rural ones. The average was over 100 (range=50 to over 250 patients)and 50 for the latter. The highest monthly averages were documented for the tertiary hospital in Lusaka, Zambia

(270 per month). Average length of stay (in days) ranged from a low of less than one day in each of the tertiary hospitals in Uganda and Zambia to approximately four days in the other non-tertiary facilities (three in each country). The difference in length of stay was less notable among the four Malawi study hospitals.

Interview data; Provider opinions: The majority of all providers in Zambia and Uganda stated that they did not have a role in providing family planning (FP) counseling to abortion patients. Among those who said they did provide post-abortion FP counseling (39/111), the overwhelming majority (67%) were nurses. In Malawi, almost half (45%) of all 33 providers interviewed said they provided FP counseling for abortion patients seeking treatment for abortion complications, and 53% of those who said they provided FP counseling were doctors. In response to the question "do you think abortion patients are interested in receiving FP information", the majority (77%) of providers in all countries responded positively although in Malawi, fewer nurses than doctors (59% versus 75%, respectively) gave this response. The majority of providers in Uganda and Zambia responded that incomplete abortion patients are not routinely provided with information about where to get FP methods in their community. In Malawi, 51% responded that patients in their hospitals are routinely given this information.

The majority of all providers in Malawi and Zambia (55% and 77% respectively) felt that FP is very easy to obtain in the surrounding community. A notable larger proportion (55%) of providers in Uganda expressed that FP is very difficult to obtain in the area. The opinion that FP was very easy to obtain was expressed substantially more often by nurses than doctors especially in Zambia (83% versus 63% respectively). Across the board, lack of information, was stated by most providers (78%) as the reason why abortion patients did not use FP prior to becoming pregnant. Differences in other reasons given by providers concerning why women don't use FP were statistically significant across the three countries for health concerns (p=0. 0001), partner disapproval (p=0. 003) and method inconvenience (p=0. 025)- with Uganda providers citing these reasons proportionately more often than providers from the other two countries. Overall, provider opinion about access to FP information among abortion complication patients was inconsistent between doctors and nurses but there was agreement on factors influencing use of FP.

While overall, 42% of the providers stated that abortion was very easy to obtain in the community, the proportion of Uganda providers who gave this response was very low (6% all of whom were nurses). In contrast, a higher proportion (29%) of Uganda providers (and 50% of the doctors interviewed from this country) stated that abortion was very difficult to obtain in the area. The difference in opinion between doctors and nurses across all countries in their opinion regarding the ease of obtaining an abortion in the community was statistically significant (p=0.013). Nurses were much more likely than doctors (52% versus 29%, respectively) to say that it was very easy to obtain an abortion and doctors were more likely than nurses to say it was very difficult to obtain an abortion (24% versus 8%, respectively).

Provider opinion regarding why women terminate their pregnancy differed by country and professional cadre. Being unmarried was noted as the reason by a high proportion (75%) of all providers. This was stated as a reason by 100% of the doctors in Malawi. In Uganda, 76% of the providers (80% of the doctors) indicated economics as a reason for seeking abortion. Overall, there was a significant difference (p=0.001) between the proportion of doctors (60%) versus nurses (25%) who felt that economics was a reason why women in their hospital seek an abortion. On the other hand, this was *not* a reason stated by the patients interviewed(2). Bad pregnancy timing was listed among the reasons by 45% of all providers and 63% of doctors and nurses interviewed in Malawi. Having children too close in time was noted by 70% of the Uganda doctors and by 42% of all providers interviewed. Having too many children was similarly cited as a reason by a high proportion of doctors and nurses in Uganda (80% and 71%, respectively versus 39% of all providers interviewed). Although rape, incest, foetal deformity and poor health were cited by relatively few providers as reasons why women seek to terminate their pregnancy, these were cited significantly more frequently by doctors compared to nurses, [rape/incest (p=0.01) and fetal deformities (p=0.010)].

Similarly, while 64% of all providers indicated that death from incomplete abortion was a major problem in their community, only 24% of Uganda providers had this opinion. Interestingly, in response to the question, who in the community provides abortion, 60% of the doctors and 33% of the nurses in Uganda said abortion providers were doctors compared to less than 20% and 5% of the doctors and nurses, respectively, from the other two countries indicating that doctors were the providers. On the other hand, traditional healer and "other" were cited most frequently in the other two countries and infrequently in Uganda. Doctors were of the opinion that doctors provided the service more often (26%) than nurses (5%) and nurses more often (49%) than doctors (26%) had the opinion that others (including the woman herself, a friend or non-health or traditional provider) were the source of abortion services. Differences in opinion regarding who provides pregnancy termination services in the community were statistically significant between nurses and doctors (p=0.004).

Providers' knowledge about the conditions under which abortion was legal or illegal in their country varied by condition and by profession. Overall, the doctors were more knowledgeable about laws pertaining to abortion. While most providers knew about the legality of abortion in the case of incest, rape and on demand (illegal for all three conditions in all three countries), there was considerable lack of knowledge about abortion laws as they pertain to foetal conditions and a woman's mental

health. Importantly, a substantial proportion of providers (55%) in Malawi did not know that abortion was legal to save the life of the woman (63% of the doctors versus 29% of the nurses correctly cited this reason). Opinions regarding whether the current abortion laws in their country are too restrictive or liberal varied among the study providers by country. While 26% of providers in Zambia (which had the least restrictive laws of the three countries at the time of the study) were of the opinion that current laws were too liberal, no providers in Uganda and only 7% in Malawi expressed this opinion. In contrast, 80% of providers in Uganda and 52% in Malawi said that the current laws were too restrictive (compared to 34% in Zambia). These responses need to be considered together with data on the level of correct provider knowledge of conditions under which abortion is legal in their country to better interpret the meaning of these results.

Patient opinions: While lack of information was the second most common reason stated for non-use of FP prior to their most recent pregnancy among the patients interviewed, only 31% overall cited this reason. This proportion differed significantly by age (49% of patients citing this reason were equal or less than 20 years versus 23% of patients more than 21 years old (p=0.010). This difference by age was particularly marked in Zambia (p=0.005) . Other reasons given by patients for non-use of FP were: not married, not yet had a child, and not yet ready to stop having children. Of interest, lack of access, cost, health concerns, and partner disapproval were cited infrequently as reasons why they did not use FP (and those who cited these reasons were mostly from non-tertiary hospitals).

Overall, there was a significant difference in whether information on where to obtain FP in the community had been given (according to patient recall) to patients treated in tertiary versus non-tertiary facilities (16% versus 32%, respectively; p=0.011). The difference was most marked in Zambia in non-tertiary versus tertiary facilities (7% versus 40%, respectively, p= 0.003). The difference was not significantly different between patients ≤20 and those aged 21 years and above. The proportion of patients who said they had used FP prior to this pregnancy was significantly different (p=0.002) for the two age groups, especially in Zambia (p=0.004). Interestingly, none of the 14 patients ≤=20 years in Malawi stated that they had ever used FP before. For the other two countries, however, 21% <=20 year olds stated that they had used FP before the index pregnancy.

In general, patients were not given FP information or methods during their hospital stay. In Uganda, 83% of patients interviewed said that "no one had talked to them about FP services during their hospital stay." There were similar responses in the other countries. Substantial percentage of patients wanted FP information and/or method available to them while they were receiving care.

For the majority (53%) of patients interviewed, their spouse or partner was paying for the abortion treatment services received. Relatives (22%) and the patient herself (16%) were the other two major categories of payees. Overall, relatives paid for services at a higher rate (32%) among adolescent patients (≤20 year olds) than among patients above 21 years (17%). Differences in payment practices were significant (p=0.015) by facility type. While 62% of patients in non-tertiary centers said a spouse or partner was paying for their treatment services, this was the case for only 37% of patients interviewed from tertiary centers. On the contrary, more clients (26%) from tertiary centers paid for services themselves than patients from non-tertiary facilities (11%).

The proportion of patients who noted that they had a friend or relative who had either died or become seriously ill from the same problem for which they were currently hospitalised differed significantly by function of the facility (tertiary versus non-tertiary; p=0.17). Overall, 38% of all patients interviewed said yes to this question and the proportion was over 30% for all three countries.

DISCUSSION

Findings generalised from the study: These primary data suggest that in these three countries the "typical" abortion patient is around 25 years of age and has two children. Women of all ages, however, do present for treatment of abortion complications and thus services need to be organised to accommodate all types of women. There was a five-fold difference in the monthly number of incomplete abortion cases among the study hospitals; the larger caseloads being seen in the urban, tertiary hospitals. While this finding has direct service implications, it also has training implications in that a consistent number of cases (minimum caseloads) are needed in clinics selected for competency-based training.

The average length of patient stay appeared to be lower in urban, tertiary (usually teaching) hospitals which have higher caseloads. It was noted that manual vacuum aspiration (MVA) was used for treating incomplete abortion cases in the tertiary hospitals in these countries but it was not used in most of the non-tertiary hospitals. MVA is a safe, simple, non-electric and effective technology for uterine evacuation. Other studies (reviewed in the *Monograph)* have shown MVA services offered in an outpatient setting to be more cost-effective than usual dilatation and curettage (D and C) treatment regimen offered as an inpatient procedure, performed in an operating theater. This primary data finding supports the introduction of MVA into more rural clinics as a potential means of reducing the average length of patient stay and associated costs and improving women's access to post abortion care.

Provider experiences and attitudes in the three selected countries were similar for some items but markedly different for others. For example, the Malawi providers interviewed seemed to be more involved in and knowledgeable about FP services in their community than the providers interviewed from the other two countries.

Provider responses from Uganda suggest that those interviewed were either less familiar with the realities of the problem in their community or that the problem of incomplete abortion manifests differently in this country. While many providers cited the timing and number of children as key reasons why women seek an abortion, many also cited other reasons, which were not mentioned by the patients themselves (e.g. economics).

Nurses seemed to feel that abortion was more accessible and that services were provided more by non-medical people than did the doctors. Study patients were not asked who terminated their pregnancy but results from other studies suggest that the nurses might be more knowledgeable about the field situation than the doctors (or than doctors' responses indicated). This calls for additional education regarding the realities of induced abortion among health professionals in these countries.

As a group, the providers were not fully knowledgeable about the conditions under which abortion is legally permitted in their country. Nurses were less knowledgeable across the three countries than the doctors in this regard. Most provider respondents expressed that existing abortion laws were either appropriate or too restrictive. The need for additional provider education regarding the legal provisions regarding abortion services in their country is critical.

The fact that a number of the patients interviewed cited an intention to have more children as the reason why they did not use FP prior to the index pregnancy suggests that patients associate FP with limiting births, not with spacing or delaying their first birth. Given that the average parity was two, and average age 25, this finding could be a function of age or the fact that at least some of these women were attempting to space the timing of their births through pregnancy termination. According to the women's interview study data, information on FP was given more often to women treated in a non-tertiary setting. If true, this likely relates to the higher client loads in tertiary clinics and the fact that these are busier clinics. This finding has important implications for programme planning as there needs to be a balance between minimum caseloads required for competency-based training (in how safely to manage incomplete abortion cases) and the maximum number of patients that can be managed by a clinic if they are to integrate FP services as part of post-abortion care.

It is noteworthy that a third of the patients, representing all ages and receiving services in facilities of different kinds, said that they knew of at least one friend or relative who had died or become seriously ill from complications of an incomplete abortion. Data collection techniques such as the sisterhood method might hold promise for obtaining estimates of the magnitude of the problem at the community level. These primary data reflect the experience of women who were attended to at select tertiary, provincial or district level hospitals. The data represent the situation as it was a decade ago in the region, and their important implications for policy and programme development.

Unanswered questions and knowledge gaps: A number of questions were raised by this study, answers to which would help prevent unwanted pregnancy and yield better designed services for the management of complications of abortion at all levels in the community. These include; What factors influence contraceptive use? How can knowledge about these factors be used to design more accessible FP services for preventing unwanted pregnancy? What factors determine the choice to terminate a pregnancy? Who performs induced abortion in the community? Why are there differences in knowledge and attitudes between patients and service providers regarding access and use of FP and abortion services? How can post abortion FP counseling and services be improved for PAC patients? How can PAC and legal abortion services be more widely available at all levels of the health care system? A wide range of studies has since been conducted to address some of these questions, and to further document the magnitude of abortion, describe the community context of abortion and assess the effectiveness of training and service delivery interventions. A summary of key findings from recent research is provided below.

Update on unsafe abortion in Africa: Recent estimates from the World Health Organisation indicate that there are more than four million unsafe abortions in Africa annually, with unsafe abortion rates of 20-29 per 1000 women of reproductive age, depending on the particular sub-region within Africa(5). At the country level, various studies have developed estimates of abortion rates and abortion-related caseloads in public hospitals. For example, in interviews conducted at a nationally representative sample of 672 health care facilities in Nigeria, Henshaw *et al.*(6) estimated that 610,000 abortions are performed nationally each year, at a rate of 25 abortions per 1000 women of reproductive age. Prior to reform of the South African abortion law, Rees *et al.*(7) estimated that almost 45,000 women per year were admitted to public sector hospitals for treatment of incomplete abortion. An ongoing study will also estimate the caseload of incomplete abortion patients in over 60 public hospitals throughout Kenya.

Two reports describe research in Africa to explore community attitudes and practices about unwanted pregnancy, abortion and contraception. In four districts in Zambia, data were collected from secondary schoolgirls, women in their homes via focus group discussions with schoolboys, girls, men and women in the community. The researcher estimated high rates of mortality from unsafe abortion, described the custom of expelling pregnant girls from school and identified the range of abortion providers and methods used. In spite of a liberal abortion law, legal services remained largely inaccessible to women in the study area(8). In Kenya, focus groups and in-depth interviews with a variety of community members (including adolescents, health workers and teachers) were conducted in a western Kenyan province. Findings included definitions of unwanted pregnancy that varied by marital status, characteristics of abortion providers and methods commonly

used and costs of abortion by provider type(9). In both the Zambian and Kenyan studies, respondents cited numerous examples of girls or women who had died from unsafe abortions.

Research to test alternative approaches to improve service quality and access has also been conducted in sub-Saharan Africa in the last decade, providing guidance to policy makers and providers and spurring expansion of services. A study in six Kenyan hospitals found that post abortion family planning provided on the obstetrics and gynaecology ward by ward staff was the most effective strategy for ensuring that PAC patients received counseling and a contraceptive method if they wished(10). The long-term benefits of post abortion family planning for PAC patients was documented in a study in Zimbabwe, in which patients who received information and contraceptive methods at the time of treatment had lower rates of repeat unplanned pregnancy and abortion one year later than patients who had not received such services(11). Intervention research in Senegal and Burkina Faso has shown the feasibility and effectiveness of changes in clinical treatment of incomplete abortion and provision of contraceptive information and services (12,13).

The role of mid-level practitioners in PAC and abortion care has also been a focus of several studies in Africa. The advantages of provision of PAC services at the primary level by trained midwives were demonstrated in Ghana(14). In a South African evaluation, midwives were documented as effective providers of abortion care services(15). A pilot project in Uganda to train midwives resulted in treatment of PAC patients at primary health centers and regional and district hospitals(16,17). Furthermore, assessments of the quality and availability of post abortion care have been conducted in a number of countries, including Nigeria, Ethiopia, Zambia and Uganda(18-21).

Significant efforts to improve training and services have occurred in a number of African countries such as Ethiopia, Ghana, Kenya, Malawi, Nigeria, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. These activities have included the development of PAC or abortion care guidelines and training curricula, incorporation of abortion-related content into pre-service and in-service clinical training programs and purchase of MVA instruments by Ministries of Health. Local training, service and commodities efforts for PAC and abortion care have often been supported by private foundations and bi-and multi-lateral development assistance organisations(22). An international conference held in 2000 in Kenya focused on addressing the challenges of PAC scale-up efforts in Africa and other regions(23).

Efforts to change abortion laws and policies are increasing in Africa. In 1996 in South Africa, a few years after the research effort described herein, the abortion law was reformed through the "Choice on Termination of Pregnancy Act" that permits legal abortion through 12 weeks of pregnancy and for certain indications later in pregnancy. Reforms of abortion laws in Benin, Burkina Faso, Djibouti and Mali have also occurred since 1994. Movements by governments or non governmental organisations to liberalise existing abortion laws are active in Kenya, Mozambique, Mauritius, Namibia, Nigeria and Uganda, while the Ethiopian Parliament is currently considering expansion of legal indications for abortion.

More than 100 African leaders from 15 countries including health ministers, parliamentarians, health care providers, women's advocates, media and lawyers participated in the first African regional conference on unsafe abortion held in Ethiopia in early 2003. The resulting call to action focused on mobilising stakeholders to prevent unsafe abortion, providing comprehensive reproductive health services and making safe abortion available to the full extent of local and national laws (Ipas, 2003).

While major advances have been made in the last decade to reduce the number of preventable deaths and injuries from unsafe abortion in Africa, major challenges remain. These include the need for increased national resources dedicated to the problem, improved women's access to abortion care and PAC services and reform of restrictive abortion laws. At the global level, an increased commitment of resources from donors and changes in policies such as the U.S. government's current "gag rule" will accelerate progress. The global "gag rule" prohibits developing country non-governmental organizations from receiving U.S. family planning funding if they provide abortion counselling or referal, provide legal services except under narrow circumstances, or engage in advocacy for legal or policy change. By reducing the availability of family planning funds, the "gag rule" can contribute to increased unwanted pregnancies and unsafe abortions.

Use of study findings for policy change: Information from our study and similar studies including the more recent ones cited above have helped to improve and hasten the process of abortion policy and programme development and implementation. Since 1994, there has been movement towards greater investment into post abortion care and improved access to and quality of services. While serious deficits in abortion-related policies and practices remain, notable progress has been made in sub-Saharan Africa since our data were collected and initial reports published.

The anticipated short-term outcome of this study was increased awareness among African health officials about the problem of incomplete abortion in SSA, especially CRHCS/ECSA countries. At the CHRCS Conference of Health Ministers held in Malawi in November, 1994, the Health Ministers from 12 Commonwealth countries reviewed and endorsed the results of this multi-center study, calling for the development of specific action plans to improve prevention and management of complication of induced abortion. At the August 1995, ECSA Director Joint Consultative Committee (DJCC) meeting, country directors of health services, dean of medical schools, and directors of national health research institutions met to discuss the findings of the "Monograph on Complications of Unsafe Abortion in Africa " and to develop regional

action plans. The resultant plans were organised by intervention focus (training, supplies/equipment, legal/ policy issues, socio/cultural issues, medical issues) and by service component (preventing the need for abortion, managing incomplete abortion cases, integrating post-abortion care into health services). Also, at the 1995 DJCC meeting, member countries reported on actions in the area of unsafe abortion that their countries had already taken to reduce maternal morbidity and mortality. Two important interventions that CRHCS country representatives described were post-abortion FP initiatives to deal with women already in clinical settings and efforts to sensitise the public about the magnitude of unsafe abortion and the importance of FP as a means of reducing abortion-related maternal deaths. The action plans developed by the DJCC were shared with Regional Health Ministers who endorsed them(24) at their 1995 annual conference.

The regional action plans were summarised in (DJCC) meeting proceedings of 1996(25) which also outlined actions CRHCS member governments might take to influence programme and policy outcomes in their respective countries:

- Constitute inter-ministerial task forces to examine the issue of abortion in its complete context.
- Develop country action plans to respond to specific issues identified by the study on consequences of unsafe abortion.
- Promote debate on consequences of unsafe abortion by supporting fora that examine the issue at various levels.
- Raise public awareness of the extent of the problem by giving more attention to women's health issues in the national media.

The global gag rule prohibits developing country non-governmental organisations from receiving U.S. family planning funding if they provide abortion counseling or referral, provide legal services except under narrow circumstances, or engage in advocacy for legal or policy change. By reducing the availability of family planning funds, the gag rule can contribute to increased unwanted pregnancies and unsafe abortions.

- Encourage policy and programme improvements by providing resources and creating mechanisms to discuss issues surrounding this problem.

CRHCS developed a work plan subsequent to the DJCC meetings with the following two objectives:

- To create awareness among policy and other decision makers in health-related areas in the region about the problems associated with the consequences of unsafe abortion in their countries.
- To persuade the target audience to initiate action plans that will solve the problems associated with unsafe abortion in their country/community.

The work plan delineated a series of activities, organised by sub-objective, which would help CRHCS to meet its two stated objectives in the area of unsafe abortion. Some of these activities have already taken place e.g. dissemination of the Monograph and the policy booklet to member states through the country information dissemination centers. The CRHCS strategically distributed the policy booklet and the Monograph at conferences and meetings in the region where maternal and child health issues were being discussed . In addition, a number of SSA Commonwealth countries have since sponsored special dissemination meetings with consequences of unsafe abortion as a feature topic. The Republic of South Africa, for example, utilised the results in the development of its Public Health Plan with subsequent liberalisation of its abortion law. At an international level, the results were presented to donor agencies with the hope of influencing policy development and increasing maternal and reproductive health funding. Over the past seven years, there has been a much greater focus on post-abortion care issues in SSA. Clearly, this research provided some impetus for stakeholders in these countries to put safe abortion on their health agenda. Continued country-level research to address programme related operational problems is critical to maintaining this momentum.

CONCLUSION

The turn around time between the availability of research results, translation of the results into policies and development of programmes responding to the research identified gaps is often quite long. This is particularly so when there are no deliberate efforts to share the results and their implications with the policy makers and programme managers. In the case of the East, Central and southern Africa Health Community, these efforts were made, yet it has still taken between five and ten years for just a few of the countries to positively respond to the results by changing policies and implementing programmes to reduce and manage complications of unsafe abortion in the region. This paper summarises previously unpublished findings from primary data collection and analysis efforts conducted some years ago, aimed specifically at informing policy and programme decision makers in the ECSA region, and adds to the mounting body of information available to such decision makers upon which important service and policy decisions can continue to be made. The paper also describes the experience of a team effort purposefully designed to conduct research to inform and influence program and policy decisions. The findings of this research have been disseminated and discussed in various ways, as a large reference monograph, as a shorter policy booklet, as individual country profiles, at professional and donor meeting presentations, and, most importantly, as part of the agenda of meetings of Health Ministers and/or Consultative meetings, where health action plans are drafted, based upon solid evidence from the region. The likelihood that findings from this research influenced abortion program and policy-decision making in the region was increased because (i) the research was conducted in collaboration with a regional health, research and training institution with direct access to programme and policy-makers in the region, as well as the fact that (ii) the

dissemination strategy took advantage of the organisation's mandate to help inform health policy and programme decisions. Attention needs to be paid to the strategy of how findings will be shared with policy makers if researchers are interested in affecting policy and programme advocacy through their efforts.

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